CHAPTER 15

HEALTHCARE ADMINISTRATION

In the Medical Department, proper records administration is very important. We are charged with administering not only routine personnel records, but also clinical records that may affect the rights and benefits of patients and their dependents years beyond retirement or discharge.

As a Hospital Corpsman, you could be assigned to or responsible for the administrative affairs concerning inpatients or outpatients. This chapter will provide information on the function of healthcare programs you may be involved with or responsible for. We will also discuss the legal implications in medical care, including the various aspects of consent, incident reports, and release or nonrelease of medical information under the Privacy and/or Freedom of Information Acts. Further, guidance concerning your relationship and interaction with law enforcement personnel and the legal community will also be outlined.

PATIENT ELIGIBILITY FOR HOSPITALIZATION AND NONFEDERAL CARE

LEARNING OBJECTIVE: *Recognize the policies and procedures for DEERS, CHAMPUS, and TRICARE.*

The fact that a person seeking treatment is or was connected with the federal government does not automatically entitle him to treatment at a naval medical treatment facility. A number of factors determine eligibility for certain types of medical attention and the source and amount of remuneration for that treatment. The following section deals with eligibility verification by presentation of a valid ID card and utilization of the Defense Enrollment Eligibility System (DEERS). Further guidance can be obtained by familiarizing yourself with the following sources:

- NAVMEDCOMINST 6320.3, *Medical and Dental Care for Eligible Persons at Navy Medical Department Facilities*
- NAVMEDCOMINST 6320.18, *Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) Regulation*
- NAVMED P-5020, *Resources Management Handbook*

DEFENSE ENROLLMENT ELIGIBILITY REPORTING SYSTEM (DEERS)

The Defense Enrollment Eligibility Reporting System (DEERS) was developed to improve distribution and control of military healthcare services. Additionally, DEERS was implemented to assist in the projection and allocation of costs for healthcare programs and to minimize fraudulent healthcare claims. Navy medicine's eligibility for care instruction, NAVMEDCOMINST 6320.3, provides guidance as to who and under what circumstances members can receive medical and dental care at Navy Medical Department facilities; the extent and conditions under which such care may be provided; and the collection process to pay for that care.

Enrollment for all seven uniformed services (i.e., Army, Air Force, Marine Corps, Navy, Coast Guard, Public Health Service, and National Oceanic and Atmospheric Administration) is accomplished through completion and submission of an ***Application for Uniformed Services Identification and Privilege Card*, DD 1172,** for a member's dependent. When a new ID card is obtained for the dependent, the member's DEERS data is updated online. If problems exist within a patient's database, active duty personnel and their dependents must be referred to the sponsor's personnel office. Refer all other beneficiaries (e.g., retired personnel and their dependents) to the nearest personnel office.

Direct Care System Procedures

In addition to providing authorization to standard medical care through inclusion in its membership database, DEERS now includes a dental policy based upon beneficiary information (versus the previous policy based on sponsor information). This change in policy occurred in part because of the increased accuracy of the database as well as the percentage of personnel enrolled.

Although DEERS and the ID card system are related, there are instances when the beneficiary is in possession of a valid ID card and the DEERS system shows the patient as ineligible or not in the database. In these instances, eligibility verification using the ID card shall not override DEERS without some other type of collateral documentation. (See sections on DEERS overrides and exceptions later in this chapter.) It must be stressed that military treatment facilities (MTFs) are to **verify** eligibility. **Establishment** of eligibility is under the cognizance of the respective service personnel offices.

Eligibility

Patients who present for non-emergency treatment without a valid ID card but who are in the DEERS database will **not** be provided medical care without first signing a statement that they are eligible and giving the reason why a valid ID card is not in their possession. If a valid ID card is not provided within 30 calendar days, the patient is referred for billing as a Civilian Humanitarian Non-indigent, in accordance with the *Resources Management Handbook*, NAVMED P-5020. Such billing may be delayed if the commanding officer of the facility is convinced proof is delayed for reasons beyond the control of the patient or sponsor. In all cases where a patient presents without an ID card and does not appear in the DEERS database, **non-emergency** care will be denied.

REASONS FOR INELIGIBILITY.—When a DEERS check is performed and the patient is found ineligible for any of the following reasons, routine non-emergency healthcare will be denied (except as noted later in this section).

- Sponsor not enrolled in DEERS
- Dependent not enrolled in DEERS
- Ineligible due to passed terminal (end) eligibility date
- Sponsor has separated from active duty
- Spouse is divorced from sponsor and is not entitled to benefits as a former spouse
- Dependent child is married

UNDER NO CIRCUMSTANCES WILL THE CLERK PERFORMING THE ELIGIBILITY CHECK DENY THE REQUESTED CARE. Only command-designated supervisory personnel can perform this function.

DEERS ELIGIBILITY OVERRIDES.—The nine "DEERS eligibility overrides" are listed below. Unless otherwise stated, all overrides must be supported by a valid ID card.

1. **DD 1172**—The patient presents an original or copy of the DD 1172 used for DEERS enrollment. There are specific items required for verification, and current service directives must be checked.
2. **All Other Dependents Recently Becoming Eligible for Benefits**—Patients who become eligible for benefits in the previous 120 days may be treated upon presentation of a valid ID card. For children under 10 years of age, a valid ID card of a parent or guardian is acceptable. Upon application for care beyond 120 days, follow the procedure in item 1, above.
3. **New Identification Card**—Patients presenting with a new valid ID card, issued within the previous 120 days, will not be denied care.
4. **Ineligible Due to ID Card Expiration**—When the database shows a patient as ineligible because of ID card expiration, care may be rendered as long as the patient has a new ID card issued within the previous 120 days. After 120 days, follow the procedure in item 1, above.
5. **Sponsors Entering Active Duty Status for a Period of Greater than 30 Days**—A copy of orders ordering a reservist or guardsman to an active duty period of greater than 30 days may be accepted for the first 120 days of the active duty period. After that, follow the procedure in step 1.
6. **Newborns**—Newborns will not be denied care for a period of 1 year following birth. The patient's birth certificate suffices when presented with a parent's valid ID card.
7. **Emergency Care**—This is a medical decision and shall be determined by criteria established within the command.
8. **Sponsor's Duty Station is Outside the 50 United States or has an APO/FPO Address**—Dependents whose sponsors are assigned outside the 50 United States or to a duty station with an APO/FPO address will not be denied care as long as the sponsor is enrolled and eligible in DEERS.
9. **Survivors**—When an eligibility check indicates that a deceased sponsor is not enrolled

in DEERS or the survivor is listed as the sponsor, the survivor will be treated on the first visit and referred to the appropriate personnel office for correction of the DEERS database. For second and subsequent visits, the survivor will be required to follow the procedure in item 1, above.

DEERS ELIGIBILITY EXCEPTIONS.—The following beneficiaries are categorized as "DEERS Eligibility Exceptions." Although authorized care, they may not be authorized to be enrolled in the DEERS system. These beneficiaries will **NOT** be denied care based upon a DEERS check.

- **Secretary of the Navy Designees**—Secretary of the Navy Designees will be treated as indicated on their letter of designation.
- **Foreign Military Personnel**—These personnel and their dependents, assigned through Personnel Exchange Programs or other means, are or may be eligible. Eligible members may also include

  —North Atlantic Treaty Organization (NATO) military personnel and their dependents stationed in or passing through the United States;

  —crew and passengers of visiting military aircraft; and

  —crews of ships of NATO nations that come into port.

Other foreign military personnel may be eligible through Public Law or DoD agreements. As such, they will be treated in accordance with current service directives.

Patients in other organizations, such as Red Cross workers, Secret Service agents, Federal Aviation Administration personnel, and some non-retiree veterans, to name a few, are also in this category. Ensure current eligibility requirements are met for these personnel prior to treatment.

TRICARE

TRICARE is an enhancement of the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). TRICARE is a medical benefits program established to enhance management of care services in military medical treatment facilities and to cost-share charges for medically necessary civilian services and supplies required in the diagnosis and treatment of illness or injury. TRICARE is also utilized if the required services are not available from the direct care system of the Department of Defense treatment facilities or designated MTFs.

Information pertaining to eligibility, extent of care, providers, cost, and claims is contained in the booklet *Sailing with TRICARE, for Sailors and Their Families*. A copy of this publication, along with the *TRICARE Provider Directory* and other helpful TRICARE information is available at your local TRICARE Service Center. A wealth of guidance is also available via the DoD TRICARE homepage, http://www.tricare.osd.mil.

NAVY MEDICINE'S QUALITY ASSURANCE PROGRAM

LEARNING OBJECTIVE: *Recall the philosophy of Navy medicine's Quality Assurance Program.*

The Quality Assurance Program is used to evaluate the degree of excellence of the results of delivered care and to make improvements so that care in the future will result in a higher degree of quality. Quality assurance activities reflect what patients and providers expect of each other. In past years, various means of reviewing and evaluating patient care have been introduced. In 1979, the JCAH Board of Commissioners imposed the requirement for hospitals to coordinate quality assurance activities and to use an ongoing monitoring system to review and evaluate the quality and need for care. This approach is effective in identifying important patient-related problems and is applicable in every healthcare delivery situation. Many of the principles, standards, and organizational requirements of JCAH have been adopted and are contained in OPNAV 6320.7, *Health Care Quality Insurance Policies for Operating Forces*. BUMEDINST 6010.13, *Quality Assurance Program*, lists the required elements for process improvement (quality assurance) programs of naval hospitals, medical clinics, and dental clinics.

PATIENT RELATIONS AND COMMAND PATIENT CONTACT PROGRAMS

LEARNING OBJECTIVE: *Recall the philosophy of the Patient Relations Program and the Command Patient Contact Program.*

Navy healthcare professionals have long understood the need for good communication and rapport between the patient and the medical department staff. The atmosphere in which patient care is given has a tremendous effect on the patient's perception of the quality of care. The quality of medical care rendered to Navy beneficiaries is superb; however, too frequently the medical care is perceived by the patient to be substandard because personnel in patient contact points are not adequately trained in interpersonal relations. Good patient rapport is an essential element of health care delivery. Many complaints voiced by patients would not occur if personnel manning critical patient contact points presented a courteous, positive, and knowledgeable attitude that reflected a genuine concern for the patient.

To this end, the Patient Relations Program was implemented through BUMEDINST 6300.10, *Health Care Relations Program*. The Patient Relations Program's primary goal is to provide assistance by intervention in and resolution of a patient's complaints or problems. The Patient Contact Program, a subset of the Patient Relations Program, ensures an effective means of resolving such issues before the patient departs the facility. As an adjunct to this goal, both programs strive to enhance the channels of communication between the hospital and the patient population, as well as among the hospital staff.

FAMILY ADVOCACY PROGRAM

LEARNING OBJECTIVE: *Recognize policies and procedures pertaining to the Family Advocacy Program.*

The purpose of the Family Advocacy Program is to identify, treat, and monitor Navy personnel engaging in spouse or child abuse/neglect (whether physical or psychological) and sexual abuse. The program, a responsibility of the Navy Military Personnel Command, is guided by SECNAVINST 1752.3 and, further, by BUMEDINST 6320.70. In each geographical location, a Family Advocacy Representative (FAR), usually a staff member of the Naval Hospital, manages the program. A basewide committee, composed of medical, line, chaplain, and Family Service Center personnel, reviews abuse cases and determines whether each case is established, suspected, or unfounded. Established cases are reported at the central registry at the Bureau of Medicine and Surgery, where service statistics are compiled and the future assignment of established abusers is monitored and controlled.

DRUG AND ALCOHOL ABUSE PREVENTION AND CONTROL PROGRAM

LEARNING OBJECTIVE: *Recognize policies and procedures pertaining to the Drug and Alcohol Abuse Prevention and Control Program .*

The Navy has established a "zero tolerance" standard for drug usage. Although prevention and punishment are still major components of the zero tolerance policy, the major emphasis has shifted to education and training. Routine after-care treatment of addiction is rarely offered to individuals found abusing drugs, and the most likely outcome of drug abuse is appropriate disciplinary action and separation from the service. Levels of alcohol-abuse treatment range from shipboard education programs to inpatient admission. Post-treatment consists of monitoring and support groups, both of which are crucial aspects of the 1-year after-care rehabilitation program.

All individuals with substance abuse problems—whether alcohol- or drug-related—are totally accountable for their actions and the consequences of them in accordance with the Uniform Code of Military Justice (UCMJ) and other relevant federal, state, and local laws. See OPNAVINST 5350.4, *Drug and Alcohol Abuse Prevention and Control*, and SECNAVINST 5300.28, *Military Substance Abuse Prevention and Control*, for additional information and guidance.

Drug and alcohol abuse is costly in terms of lost work hours and unnecessary administrative and judicial processing and is a critical drawdown on morale and esprit de corps. It undermines the very fiber of professional readiness, safety, discipline, judgment, and loyalty. It is not only the abuser who is affected, but the abuser's shipmates as well. "Zero tolerance" recognizes that drug and alcohol abuse is incompatible with the maintenance of high standards of performance, military discipline, and readiness, and is destructive of Navy efforts to instill pride and professionalism in its members.

PREVENTION

Prevention programs are an important aspect of military life. **PREVENT 2000** (Personal Responsibility and Values, Education and Training) is a program designed specifically for the younger Sailor. **ADAMS** (Alcohol and Drug Abuse, Managers and Supervisors) is required for E-5 and above.

Most commands have full-time or collateral-duty **DAPA**s, Drug and Alcohol Program Advisors, who provide the direct liaison between law enforcement, medical, the Family Services Center, and the commanding officer in all matters dealing with intervention, identification, and treatment. The DAPA coordinates on-site training, facilitates Alcohol Anonymous meetings, and provides referrals for outside intervention and inpatient treatment if indicated. Personnel can be identified to the DAPA through aberrant behavioral patterns, suspicious medical findings, and by self-referral to either medical or the chaplain's office.

CONTROL

Medical personnel become professionally involved in substance abuse programs when called upon to withdraw blood or urine from an individual suspected of drug or alcohol abuse. Few areas cause as much concern and confusion to healthcare providers as the question of when those bodily fluids may be lawfully extracted.

At the outset, a few basic facts must be discussed.

1. The healthcare provider should not undertake a fluid extraction procedure when to do so is medically contraindicated.
2. Refusal to perform an extraction in the face of lawful authority could subject the healthcare provider to charges of obstruction of justice or willful disobedience of an order.
3. The healthcare provider is not an arbiter of the law. (In other words, the admissibility of evidence derived from a blood or urine sample is not a matter for Medical Department personnel to decide.)
4. Common sense and cooperation with command and law enforcement officials should be the guideposts in every instance where extraction of bodily fluids is an issue.

The following are the circumstances where withdrawal of blood or urine from active duty military members is authorized:

- **Consensual withdrawal**—If an individual expressly consents to an extraction of bodily fluids and there is a legitimate reason for the extraction, the healthcare provider may perform the procedure.
- **Valid medical purpose**—Specimens may be obtained from an individual for a valid medical examination, provided the individual has expressly or implicitly consented to the examination.
- **Competence for duty examinations**—The Competence for Duty Examination request form (NAVMED 6120/1) contains a block for the submitting authority to request laboratory analysis. See figures 15–1 and 15–2. The following procedures should be used in handling competence for duty requests.

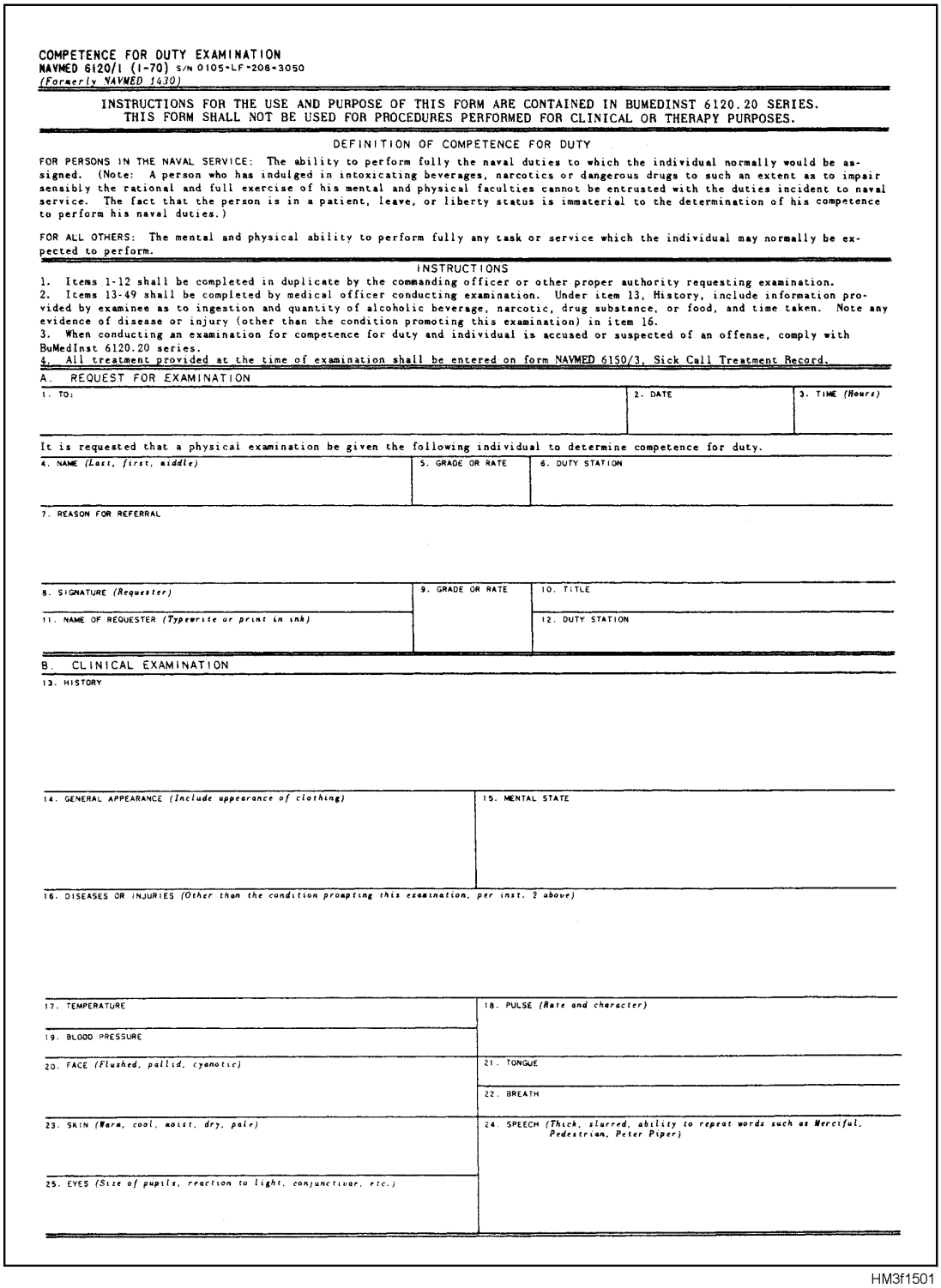
  —The command initiating the request should complete items 1 through 12 of the form. The individual submitting the request must have authority to make the request. Normally, this will be a commanding officer, executive officer, or command duty officer of the initiating command.

  —After proper initiation of the request, the medical officer or other authorized healthcare provider will complete blocks 13 through 49 on the form.

  —If the command has requested laboratory analysis, the patient should first be requested to give written consent to the procedure. If the patient will not give consent but will allow extraction, the sample should be taken. If the patient refuses consent and will physically resist extraction, the requesting command should be notified and no extraction attempted unless a search authorization is issued.

PHYSICAL READINESS PROGRAM

LEARNING OBJECTIVE: *Recognize the policies and procedures pertaining to the Physical Readiness Program.*



COMPETENCE FOR DUTY EXAMINATION
NAVMED 6120/1 (1-70) S/N 0105-LF-208-3050
(Formerly NAVMED 1430)

INSTRUCTIONS FOR THE USE AND PURPOSE OF THIS FORM ARE CONTAINED IN BUMEDINST 6120.20 SERIES.
THIS FORM SHALL NOT BE USED FOR PROCEDURES PERFORMED FOR CLINICAL OR THERAPY PURPOSES.

DEFINITION OF COMPETENCE FOR DUTY

FOR PERSONS IN THE NAVAL SERVICE: The ability to perform fully the naval duties to which the individual normally would be assigned. (Note: A person who has indulged in intoxicating beverages, narcotics or dangerous drugs to such an extent as to impair sensibly the rational and full exercise of his mental and physical faculties cannot be entrusted with the duties incident to naval service. The fact that the person is in a patient, leave, or liberty status is immaterial to the determination of his competence to perform his naval duties.)

FOR ALL OTHERS: The mental and physical ability to perform fully any task or service which the individual may normally be expected to perform.

INSTRUCTIONS

1. Items 1-12 shall be completed in duplicate by the commanding officer or other proper authority requesting examination.
2. Items 13-49 shall be completed by medical officer conducting examination. Under item 13, History, include information provided by examinee as to ingestion and quantity of alcoholic beverage, narcotic, drug substance, or food, and time taken. Note any evidence of disease or injury (other than the condition promoting this examination) in item 16.
3. When conducting an examination for competence for duty and individual is accused or suspected of an offense, comply with BuMedInst 6120.20 series.
4. All treatment provided at the time of examination shall be entered on form NAVMED 6150/3, Sick Call Treatment Record.

A. REQUEST FOR EXAMINATION

1. TO: | 2. DATE | 3. TIME *(Hours)*

It is requested that a physical examination be given the following individual to determine competence for duty.

4. NAME *(Last, first, middle)* | 5. GRADE OR RATE | 6. DUTY STATION

7. REASON FOR REFERRAL

8. SIGNATURE *(Requester)* | 9. GRADE OR RATE | 10. TITLE

11. NAME OF REQUESTER *(Typewrite or print in ink)* | 12. DUTY STATION

B. CLINICAL EXAMINATION

13. HISTORY

14. GENERAL APPEARANCE *(Include appearance of clothing)* | 15. MENTAL STATE

16. DISEASES OR INJURIES *(Other than the condition prompting this examination, per inst. 2 above)*

17. TEMPERATURE | 18. PULSE *(Rate and character)*

19. BLOOD PRESSURE

20. FACE *(Flushed, pallid, cyanotic)* | 21. TONGUE

22. BREATH

23. SKIN *(Warm, cool, moist, dry, pale)* | 24. SPEECH *(Thick, slurred, ability to repeat words such as Merciful, Pedestrian, Peter Piper)*

25. EYES *(Size of pupils, reaction to light, conjunctivae, etc.)*

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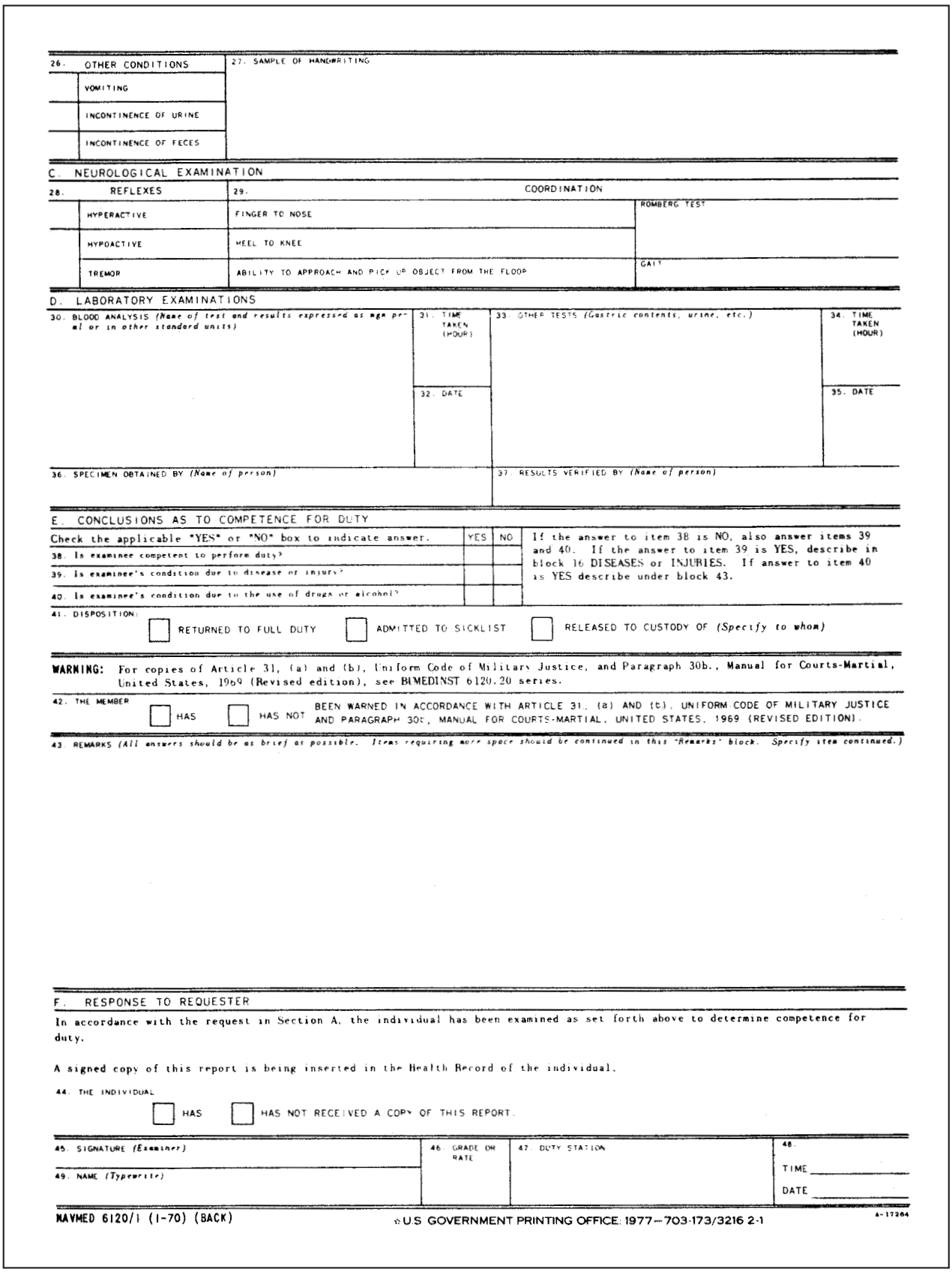
Figure 15–1.—NAVMED 6120/1, *Competence for Duty Examination request form* (front).

The policies governing this program are outlined in OPNAVINST 6110.1. Currently, physical readiness testing is required for all personnel on a semi-annual basis. Testing, education, and training advice are provided through a network of collateral duty command fitness coordinators. In addition to the requirement for program implementation by each subordinate command, Medical Department responsibilities are

- providing technical assistance to BUPERS,
- conducting lifestyle, fitness, and obesity research,



26. OTHER CONDITIONS
- VOMITING
- INCONTINENCE OF URINE
- INCONTINENCE OF FECES

27. SAMPLE OF HANDWRITING

C. NEUROLOGICAL EXAMINATION

28. REFLEXES
- HYPERACTIVE
- HYPOACTIVE
- TREMOR

29. COORDINATION
- FINGER TO NOSE
- HEEL TO KNEE
- ABILITY TO APPROACH AND PICK UP OBJECT FROM THE FLOOR
- ROMBERG TEST
- GAIT

D. LABORATORY EXAMINATIONS

30. BLOOD ANALYSIS *(Name of test and results expressed as mgs per ml or in other standard units)*

31. TIME TAKEN (HOUR)

32. DATE

33. OTHER TESTS *(Gastric contents, urine, etc.)*

34. TIME TAKEN (HOUR)

35. DATE

36. SPECIMEN OBTAINED BY *(Name of person)*

37. RESULTS VERIFIED BY *(Name of person)*

E. CONCLUSIONS AS TO COMPETENCE FOR DUTY

Check the applicable "YES" or "NO" box to indicate answer.	YES	NO
38. Is examinee competent to perform duty?		
39. Is examinee's condition due to disease or injury?		
40. Is examinee's condition due to the use of drugs or alcohol?		

If the answer to item 38 is NO, also answer items 39 and 40. If the answer to item 39 is YES, describe in block 16 DISEASES or INJURIES. If answer to item 40 is YES describe under block 43.

41. DISPOSITION:
☐ RETURNED TO FULL DUTY ☐ ADMITTED TO SICKLIST ☐ RELEASED TO CUSTODY OF *(Specify to whom)*

WARNING: For copies of Article 31, (a) and (b), Uniform Code of Military Justice, and Paragraph 30b., Manual for Courts-Martial, United States, 1969 (Revised edition), see BUMEDINST 6120.20 series.

42. THE MEMBER ☐ HAS ☐ HAS NOT BEEN WARNED IN ACCORDANCE WITH ARTICLE 31, (a) AND (b), UNIFORM CODE OF MILITARY JUSTICE AND PARAGRAPH 30c, MANUAL FOR COURTS-MARTIAL, UNITED STATES, 1969 (REVISED EDITION).

43. REMARKS *(All answers should be as brief as possible. Items requiring more space should be continued in this "Remarks" block. Specify item continued.)*

F. RESPONSE TO REQUESTER

In accordance with the request in Section A, the individual has been examined as set forth above to determine competence for duty.

A signed copy of this report is being inserted in the Health Record of the individual.

44. THE INDIVIDUAL ☐ HAS ☐ HAS NOT RECEIVED A COPY OF THIS REPORT.

45. SIGNATURE *(Examiner)*

46. GRADE OR RATE

47. DUTY STATION

48.
TIME _____
DATE _____

49. NAME *(Typewrite)*

NAVMED 6120/1 (1-70) (BACK)

☆U.S. GOVERNMENT PRINTING OFFICE: 1977—703-173/3216 2-1

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Figure 15–2.—NAVMED 6120/1, *Competence for Duty Examination request form* (back).

- reviewing health status and granting waivers for those individuals unable to safely participate in physical fitness testing and training, and
- assisting in the development of exercise prescriptions.

LEGAL IMPLICATIONS IN MEDICAL CARE

LEARNING OBJECTIVE: *Recognize the policies and procedures pertaining to consent for medical treatment, incident reports, and release of medical information.*

There are few aspects of medical administration of treatment that do not have some legal implications. Every time a patient comes into contact with a facility or its staff members, either directly or indirectly, formally or informally, the potential for legal entanglement exists. Although the law has become more and more involved in the operation of hospitals, the exercise of common sense combined with a knowledge of those situations that require special care will protect the hospital and its staff from most difficulties.

This section addresses some of the situations that regularly arise and have legal consequences, including the policy and instructions that apply to those situations. Keep in mind that the law is an inexact science, subject to widely varying circumstances. The information in this chapter cannot substitute for the advice of an attorney. Hospital staff members are encouraged to consult with hospital or area Judge Advocate General (JAG) Corps officers on issues with which they are uncomfortable.

CONSENT REQUIREMENTS FOR MEDICAL TREATMENT

With limited exceptions, every person has the right not to be touched without his having first given permission. This right to be touched only when and in the manner authorized is the foundation of the requirement that consent must be obtained before medical treatment is initiated. Failure to obtain consent may result in the healthcare provider being responsible for an assault and battery upon the patient.

Informed Consent

While the term "consent" in the medical setting refers to a patient's expressed or implied agreement to submit to an examination or treatment, the doctrine of "informed consent" requires that the healthcare provider give the patient all the information necessary for a knowledgeable decision on the proposed procedure. When courts say that a patient's consent must be informed, they are saying that a patient's agreement to a medical procedure must be made with full awareness of the consequences of the agreement. If there is no such awareness, there has been no lawful consent.

The duty to inform and explain rests with the provider. **THIS RESPONSIBILITY CANNOT BE DELEGATED**.

The provider must describe the proposed procedure in lay terms so the patient understands the nature of what is proposed. The risks of the treatment must be explained. If there are any alternative medical options, they should be disclosed and discussed.

For common medical procedures that are considered simple and essentially risk free, a provider is not required to explain consequences that are generally understood to be remote. A determination of what is simple and common should be made from the perspective of appropriate medical standards. Where the harm that could result is serious or the risk or harm is high, the duty to disclose is greater.

Methods should be developed within each hospital department to acquaint patients with the benefits, risks, and alternatives to the proposed treatment. In some departments, prepared pamphlets or information sheets may be desirable. In others, oral communication may be the best method. Some states (e.g., Texas) have laws that are very specific about what is required.

Emergency Situations

Consent before treatment is not necessary when treatment appears to be immediately required to prevent deterioration or aggravation of a patient's condition, especially in life-threatening situations, and it is not possible to obtain a valid consent from the patient or a person authorized to consent for the patient. The existence and scope of the emergency should be adequately documented.

Who May Consent

The determination of who has authority to consent to medical treatment is based on an evaluation of the competency of the patient. If competent, usually the patient alone has the authority to consent. Competency refers to the ability to understand the nature and consequences of one's decisions. In the absence of contrary evidence, it may be assumed that the patient presenting for treatment is competent. If the patient is incompetent, either by reason of statutory incompetence (e.g., a minor) or by reason of a physical or mental impairment, the inquiry must turn to whoever has the legal capacity to consent on behalf of the patient. Parents and guardians will usually have the authority to consent for their minor child or children. In many states, though not all, a husband or wife may give consent for an incompetent spouse. It is the law of the state in which the hospital is located that controls the question of "substitute consent."

Forms of Consent

Consent for medical treatment should be obtained through an open discussion between the provider and patient during which the patient expressly agrees to the procedure. The consent should then be documented by having the patient sign any appropriate forms and by the provider noting any important details of the discussion in the medical record.

In certain limited circumstances, the consent of an individual to simple medical treatment may be implied from the circumstances. Implied consent arises by reasonable inference from the conduct of the patient or the individual authorized to consent for the patient. Reliance on this form of consent is strongly discouraged except in the most routine, risk-free examinations and procedures.

Witness to Consent

Any competent adult may witness the patient's consent. It is preferable that the witness be a staff member of the hospital who is not participating in the procedure. It is not advisable for a relative of the patient to act as a witness.

Duration of Consent

A consent is valid as long as there has been no material change in the circumstances between the date that consent was given and the date of the procedure. It is desirable that a new consent be obtained if there is a significant time lapse or if the patient has been discharged and readmitted due to postponement of the procedure.

INCIDENT REPORTS

When an event occurs that harms an individual, illustrates a potential for harm, or evidences serious dissatisfaction by patients, visitors, or staff, then a risk-management incident has taken place. Examples of such episodes could include the following:

- A patient's family helps him out of bed despite directions to the contrary by staff members. The patient falls and is injured.
- Excessive silver nitrate is put into the eyes of a newborn, impairing vision.
- The mother of the child complains about the care that has been given to her child and informs a staff member that she is going to talk to her lawyer about what has happened.

When a member of the staff becomes aware of an incident, he has a responsibility to make the hospital command aware of the situation. The mechanism for doing this is the **incident report** system. Incident reports are designed to promptly document all circumstances surrounding an event, to alert the commanding officer, quality assurance coordinator, and other involved administrators and clinicians of a potential liability situation, and, in a broader sense, to establish an information base on which to monitor and evaluate the number and types of incidents that take place in the facility.

Because incident reports, by their very nature, contain a great deal of information that would be of interest to persons filing claims or lawsuits against the Navy for alleged substandard medical care, and because the law recognizes the need for hospitals to have a reliable means of discovering and correcting problems, most states have enacted laws that make incident reports confidential. In other words, a person cannot obtain a copy of an incident report to help in their legal action against the hospital.

However, incident reports can lose their "protected" status if they are misused or mishandled. It is important, therefore, to treat these reports like other confidential documents. You must strictly limit the number of copies made and the distribution of the reports. Do not include the report in the patient's treatment record. The report should be limited to the facts and must not contain conclusions. Finally, the

report should be addressed and forwarded **directly** to the quality assurance coordinator of the hospital.

Further guidance concerning the Risk Management Program, the program that governs incident reports, can be found in BUMEDINST 6010.21.

RELEASE OF MEDICAL INFORMATION

Two federal statutes, the **Privacy Act** and the **Freedom of Information Act** (FOIA) combine to establish the criteria for collecting, maintaining, and releasing medical treatment records.

Freedom of Information Act

The Freedom of Information Act governs the disclosure of documents compiled and maintained by government agencies. A written request for Department of the Navy records that explicitly or implicitly refers to FOIA must be responded to in accordance with the provisions of the Act. The Department of the Navy will make available to any person all documents, not otherwise exempt, provided the requester reasonably describes the records sought and promises to pay for reasonable search and photocopy costs. Each naval activity is responsible for developing procedures for ensuring the prompt handling, retrieval, and review of requested records. The official having responsibility for the records has 10 working days to respond to the requester.

A naval record will be withheld only when it is exempt from disclosure under FOIA. One basis for exempting a record from disclosure applies to personnel, medical, and similar files, the release of which would constitute a clearly unwarranted invasion of personal privacy. This concern over clearly unwarranted privacy intrusion is reflected in the provisions of the Privacy Act.

Privacy Act

The public's concern over the inner workings and functioning of the government was the reason for the creation of the FOIA. However, it became obvious that a balance had to be made between the public's right to know and other significant rights and interests. One of these competing interests was the protection of an individual's personal right to privacy. In response to this need, the Privacy Act of 1974 was enacted. The stated purpose of the Privacy Act is to establish safeguards concerning the right to privacy by regulating the collection, maintenance, use, and dissemination of personal information by federal agencies.

The Privacy Act requires federal agencies to

- permit an individual to know what records pertaining to him are collected, maintained, used, or disseminated by the agency;
- permit an individual to prevent records pertaining to him and obtained by the agency for a particular purpose from being used or made available for another purpose without the individual's consent;
- permit an individual to gain access to information pertaining to him in federal agency records, have a copy made for all or any portion thereof, and correct or amend such records;
- collect, maintain, use, or disseminate any record of identifiable personal information in a manner that ensures such action is for a necessary and useful purpose, that the information is current and accurate, and that adequate safeguards are provided to prevent misuse of such information;
- permit exemptions from the requirements of the Privacy Act only in those cases where there is specific statutory authority to do so; and
- be subject to civil suits for any damages that occur as a result of willful or intentional violation of any individual's rights under the Privacy Act.

In addition, any officer or employee of an agency who willfully violates certain provisions of the Privacy Act is subject to criminal prosecution and fines.

Under the Privacy Act's provisions concerning disclosure of information, there are several circumstances under which naval treatment records and their contents can be disclosed. Included are disclosures to employees of the Department of the Navy who have a need to know the information. Also included are disclosures to a person under compelling circumstances affecting health or safety, pursuant to a court order, and to another government agency for civil or criminal law enforcement activities. Circumstances under which the release of medical information is appropriate are discussed in chapter 12, *Health Records*, and in the section of this chapter concerning law enforcement personnel.

MEDICAL CONDITIONS AND LAW ENFORCEMENT PERSONNEL

LEARNING OBJECTIVE: *Recognize the policies and procedures pertaining to prisoner patients, victims of alleged sexual assault and rape, substance abuse and control, probable-cause searches, and line-of-duty and misconduct investigations.*

Some medical conditions, by their very occurrence, will result in the involvement of law enforcement personnel. Individuals who are injured while committing a criminal offense; victims of abuse, neglect, or assault; impaired or injured as a result of drug abuse; or injured as a result of a traffic accident will often be the subject of an official investigation. Many times the investigators will want to question the patient or the healthcare providers treating the patient. Often, the medical records of the patient will be requested by the authorities. Occasionally, officials will want to take the patient into custody.

Under the Posse Comitatus Act, a federal statute enacted in 1956 (18 U.S.C. § 1385), it is unlawful for the U.S. military to be used to enforce or assist in the enforcement of federal or state civil laws. There are many exemptions to this act, but the issue for healthcare providers is settled by asking the following question: *"Is the medical procedure being done on this patient for a legitimate medical reason, or is it only being performed to assist civil law enforcement?"* Provided there is a reasonable medical justification for the procedure, the results of the procedure may be shared with civil law enforcement officials under the circumstances discussed below.

Cooperation with law enforcement officials, to the extent possible, is required. Provided there are no medical contraindications, patients who are either suspected of having committed an offense or who are presumed victims of criminal activity will be made available to speak with investigators. As discussed previously, access to medical treatment records is governed by the Privacy Act and FOIA. Generally, records of patients may be made available to U.S. Navy investigators once they have established a need to know the information. This determination will usually be made by the hospital JAG or public affairs officer. Other Department of Defense, federal, state, or local law enforcement officers may have access to treatment records if access is necessary as part of a criminal investigation and there is no unwarranted violation of the privacy rights of the individual involved. Similarly, local health and social service departments may be provided information from the record. The same guidelines that apply to access to treatment records apply to staff members' discussing with investigating officers the details of the medical treatment provided to a patient.

DELIVERY OF A PATIENT UNDER WARRANT OF ARREST

No patient may be released from treatment before it is medically reasonable to do so. Once it is determined that the individual can be released without significant risk of harm, the following guidelines regarding release to law enforcement authorities apply.

- **Nonactive Duty Patients**—When a nonactive duty patient is released from medical treatment, the facility no longer exercises any degree of control, and normal legal processes will occur. No official action by hospital personnel is required before local authorities take custody of the released patient. There may be occasions, however, when law enforcement officials should be notified of an imminent release of a patient.

- **Active Duty Patients**—The commanding officer is authorized to deliver personnel to federal law enforcement authorities who display proper credentials and represent to the command that a federal warrant for the arrest of the individual concerned has been issued. There are circumstances in which delivery may be refused; however, guidance should be sought from a judge advocate of the Navy or Marine Corps when delivery is to be denied.

Normally, it is the responsibility of the permanent command to take custody and control of an active duty member suspected of committing an offense. If the member is an unauthorized absentee and the command to which he is assigned is not in the same geographic area as the treatment facility, release of the patient should be coordinated with the nearest Transient Personnel Unit or Military Prisoner Escort Unit. Close liaison with the member's permanent command should also be established.

In cases where delivery of an active duty patient is requested by local civil authorities, and the treatment facility is located within the requesting jurisdiction or aboard a ship within the territorial waters of such jurisdiction, commanding officers are authorized to

deliver the patient when a proper warrant is presented. Whenever possible, a judge advocate of the Navy or Marine Corps should be consulted before delivery. If the treatment facility is located outside the jurisdiction requesting delivery, only a General Courts-Martial authority (as defined by the Uniform Code of Military Justice, Manual for Courts-Martial, and Navy Regulations) is authorized to arrange for delivery of such the patient. Extradition, return agreements, and other prerequisites to delivery will have to be completed.

When disciplinary proceedings involving military offenses are pending, the treatment facility should obtain legal guidance from a judge advocate before delivering a patient to federal, state, or local authorities. When the commanding officer considers that extraordinary circumstances exist which indicate that delivery should be denied, then the Judge Advocate General of the Navy must be notified of the circumstances by message or phone.

PRISONER PATIENTS

Prisoner patients fall into three categories of eligible beneficiaries:

- Enemy prisoners of war and other detained personnel
- Nonmilitary federal prisoners
- Military prisoners

Enemy Prisoners of War and Other Detained Personnel

Enemy prisoners of war and other detained personnel are entitled to all necessary medical and dental care, subject to the availability of care and facilities.

Nonmilitary Federal Prisoners

Nonmilitary federal prisoners are authorized only emergency medical care. When such care is being provided, the institution to which the prisoner is sentenced must furnish the security personnel to ensure custody of the prisoner and safety of others in the facility. Upon completion of emergency care, arrangements will be made immediately to transfer these individuals to a nonmilitary treatment facility or for return to the institution to which sentenced.

Military Prisoners

Status of Forces policy is to protect, to the maximum extent possible, the rights of U.S. personnel who may be subject to criminal trial by foreign courts and imprisonment in foreign prisons. Active duty members are generally not separated from the service until they have completed their term of imprisonment and returned to the United States. During this confinement, they will normally remain healthcare beneficiaries.

Military prisoners (those sentenced under the Uniform Code of Military Justice) whose punitive discharges have been executed but whose sentences have not expired are authorized medical and dental care. Individuals on appellate leave, awaiting execution of a punitive discharge, are also entitled to care. Military prisoners whose punitive discharges have been executed and who require hospitalization beyond expiration of their sentences are not eligible for care, but they may be hospitalized as civilian humanitarian nonmilitary indigents until disposition can be made to some other facility.

SEXUAL ASSAULT AND RAPE

Sexual assault and rape are criminal offenses, often associated with serious injury. The management of cases involving sexual assault and rape must be a joint medical and legal function. A sexual assault investigation kit, supplied by the Naval Criminal Investigative Service, is used to gather and preserve evidence of a crime. Included in this kit are step-by-step procedures for the examination of the patient, as well as a checklist of specimens to be collected.

In order to safeguard and obtain evidence to be used in possible legal proceedings, liaison between the naval treatment facility, military and civil investigative agencies, and state and local agencies (such as Child and Spouse Protective Services) should be established. It must be kept in mind that medical personnel are not to judge, defend, or prosecute the individuals involved. NAVMEDCOMINST 6310.3, *Management of Alleged or Suspected Sexual Assault and Rape Cases*, provides further guidance for the care, evaluation, and medico-legal documentation of the victim of an alleged rape or sexual assault.

Every effort must be made to treat the patient with respect and courtesy and to provide appropriate privacy. In dealing with alleged victims of sexual

assault, careful attention to psychological factors must be given to lessen the impact of the incident. This is especially important when a minor is involved and the reaction of adults may be more harmful than the actual assault itself. Tactful questioning and the use of appropriate terminology are of extreme importance throughout the history taking and examination. OPNAVINST 1752.1, *Sexual Assault Victim Intervention (SAVI) Program,* and SECNAVINST 5800.11, *Victim and Witness Program*, provide guidance for the care and support of victims of sexual assault.

CHILD AND SPOUSE ABUSE AND NEGLECT

The nature of child and spouse abuse and neglect requires a careful patient history and physical examination to identify or rule out past and present injuries caused by abuse or neglect. The policies and guidelines established by the Navy Family Advocacy Program must be followed. This program was discussed earlier in this chapter and is outlined in SECNAVINST 1752.3 and BUMEDINST 6320.70.

SUMMARY

Retaining our high medical standards and the quality healthcare the fleet demands, as well as providing care for military dependents and a constantly expanding retiree database, requires a healthcare administration support structure that is second to none. DEERS management and the determination of patient eligibility are crucial components and only two of the areas discussed in this chapter. Also covered were many of the health-related programs established to benefit and support eligible recipients in the military community. These programs are often meant to eliminate the need for others. Good quality assurance, for example, creates better patient relations, thereby minimizing legal problems; substance abuse and family advocacy programs identify problems before they become unmanageable; and the physical readiness program helps build a healthier Sailor, thus eliminating needless patient visits.

This chapter also provided an overview of the Hospital Corpsman's responsibilities in the area of interaction with legal authorities. Sexual assault, spouse and child abuse, and drug and alcohol incidents require legal and medical teamwork. Many legal battles are lost because of failure to adhere to the proper administrative procedures. As a Hospital Corpsman, you must be aware of these procedures and ensure that they are followed precisely.